

First Name:		Last Name:	
Pt ULI:		DOB (m/d/y):	
Address:			
Phone (Cell):		Phone (Home):	
Next Of Kin:	Relationship:	Phone:	
Consent To Consult (Patient or NOK)? Y N		Extended Health Coverage? Y N	
Consent to Review Health Authority Records? Y N			

GP/NP INFORMATION

GP/NP:	Billing Number:
Telephone:	Fax:

Reason for Referral (Presenting Problems & Expected Outcome):

Medical Conditions & Surgeries:

Current Medications:

Allergies:

Current / Previous Psychiatric History:

Identified risk:	Concern	Identified risk	Concern	Identified Risk:	Concern
Health issues		Recent loss of loved one		Alcohol / substance use	
Cognitive changes		Recent stressful event		Driving concerns	
Aggression (physical / verbal)		Self-neglect		Financial abuse	
Behavioral changes		Mood changes		Physical abuse	
Suspiciousness / paranoia		Suicidal thoughts		Homeless or at risk	
Wandering		Disturbed sleep		Falls / Gait disorder	
Client lives alone		Appetite changes		Freq hospitalizations	
Firearm / Weapons / gun		Caregiver stress		Other	